II. KEY CROSS-CUTTING AND CROSS-SECTOR DISABILITY ISSUES

Disability issues cut across all sectors and thematic areas of the World Bank, and yet are often invisible when it comes to the design of a project or program. Given the significant share of the world's population that is considered disabled, reaching and including these people and their families in the design, implementation, monitoring and evaluation of Bank projects, programs, CAS or PRSPs has great potential.

Most disability issues have multi-sector implications and are best addressed effectively not only within the framework of a single sector, but cross-sectorally. The many cross-cutting disability issues include high rates of poverty and vulnerability to poverty; difficult access to human and productive and other resources; high prevalence in countries affected by conflict and disaster, high correlation with violence, abuse and neglect.

High rate of poverty and vulnerability to poverty

People with disabilities in developing countries are over-represented among the poor. Some estimates suggest that roughly between 15 and 20 percent of poor people living in developing countries are disabled.[13] They have been largely overlooked in the development agenda so far, but focus over the last decade on poverty reduction strategies has provided an important entry point in which to rethink and rewrite the disability and inclusion agenda. Take for example, the Millennium Development Goal on the eradication of extreme poverty and hunger--this goal cannot be achieved without taking into consideration people with disabilities.[14]

Poverty and disability are both a cause and consequence of each other. Due to limited data, it is difficult to make a global statement on the relationship between disability and poverty, but data from a number of countries suggests a strong relationship (Box 5).

Box 5: Around the World—Poverty and Disability

- In Uganda, households with disabled heads are 38 percent more likely to be poor than their non-disabled counterparts; in Georgia, that figure is 30 percent.
- In Guyana, the unemployment rate for disabled adults is 67 percent;
- In Serbia, 70 percent of disabled people are poor and only 13 percent had access to employment
- In Romania, poverty rates are nearly double for households with a disabled member
- In Sri Lanka, 90 percent of disabled people are poor and unemployed.
- In United States, 51 percent of people in long term poverty (>3 yrs) have a disability
- In Nicaragua, disabled people have lower rates of education and economic activity, and higher rates of illiteracy
- In India, disabled people were more likely to be poor, hold fewer assets, and incur greater debts.

Source: Hoogeveen, J. G. (2005); World Bank (2002); World Bank (2006); Tudawe (2001); Sipos (2006); Harris-White (1996).

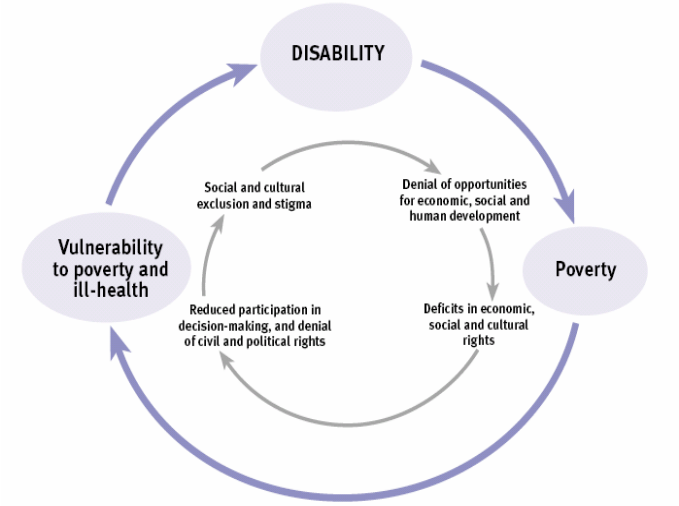
Poverty can lead to disability through malnourishment, poor access to health services (including maternal health), poor sanitation, or unsafe living and working conditions. Conversely, having a disability can entrap an individual in poverty by limiting their access to education, employment, public services, and even marriage.[15] These barriers include intense stigma, as well as barriers

[13] Elwan (1999).
[14] World Bank Disability website: http://www.worldbank.org/disability.
[15] Mont (2004).

related to infrastructure and program design.[16] The two-way link between poverty and disability creates a vicious circle (Figure 2). Moreover, the impact of disability goes beyond disabled people themselves to also include their family members. A study in Uganda shows a significant drop off in school attendance for children with disabled household heads. [17] In Nicaragua, family members spent on average 10 hours a day caring for disabled people that in turn affect their employment opportunities and other home production.

Yet, these figures probably underestimate the extent of poverty among disabled people. As economist Amartya Sen recently noted,[18] the poverty line for disabled people should take into account the extra expenses they entail in translating their income into the freedom to live well. Disability adds to the cost of living, for example with extra medical care or more expensive transportation.[19] To do the same things as a non-disabled person, a person with disability may need more income than the non-disabled person. Studies have shown that the poverty rate for disabled people doubles if these extra costs are taken into account.[20]

Figure 2. The Poverty/Disability cycle



(Source: DfID, 2000)

Employment

The livelihoods and economic opportunities of disabled people are often highly compromised because they are more likely to be excluded from services, social contracts and community activities. Such exclusion also imposes direct costs on society by reducing the economic and

[16] World Bank (2005b).
[17] World Bank (2005b).
[18] In Sen's keynote address at the World Bank's conference on "Disability and Inclusive Development" 2004.
[19] Sen (2004) describes distinction between two types of handicap that tend to go with disability: Earning handicap and conversion handicap. The former indicates the disadvantage on income and wealth, based on difficulty in getting or retaining a job, and possibly on lower compensation for work due to disabilities. The latter refers to the disadvantage that a disabled person has in converting money into good living.
[20] A study in the United Kingdom found that the poverty rate for disabled people was 23 percent compared to 18 percent for non-disabled people, but when extra expenses associated with being disabled were considered, the poverty rate for people with disabilities increased to 47 percent (Kuklys, 2005).

social output, not only of those with disabilities but also of those who care for them and whose productive employment may be reduced as a result.[21]

Employment is a key factor in the empowerment and inclusion of people with disabilities. In reality, however, the majority of adults with disabilities remain unemployed despite their potential and/or their desire to contribute to the work force. In the 1990s, for example, unemployment rates for disabled adults were 80 percent higher in OECD countries than for non-disabled people, contributing to a lower overall unemployment rate.[22] People with disabilities often face social stigmas from employers, co-workers and society, and from a young age they lack opportunities for education and training—especially women, youth, and those in rural areas.[23]

While employment rates of people with disabilities are low, it varies sharply by the type of disability. For example, people living with mental illness, psycho-social or neurological health problems, as well as mental retardation, often have a much lower probability of being employed, even in cases when such disabilities are not severe.

Persons with disabilities have unique differences and abilities. While many require the same education, vocational training, employment, and business opportunities as the non-disabled, those with more severe disabilities may require specialized support services, assistive devices or job accommodations, which may each entail a small upfront investment that yields productivity and a lifetime of economic access.[24]

Another dimension for consideration in project-level programming includes the problem of occupational hazards and work-related accidents. About 120 million occupational accidents are estimated to occur annually, with 200,000 fatalities, and even more long-term poor health and disabilities. Some 70 to 160 million new cases of occupational illness and disability may be caused by exposure to hazardous materials or chemicals at work.[25] Trends emerging from the reported data indicate that while accidents and some work-related diseases are declining in industrialized countries, they are increasing in rapidly industrializing countries, and are likely to continue to increase as industrialization gains momentum.[26]

HIV/AIDS Prevention and Care

HIV/AIDS issues among people with disabilities is often an overlooked concern, due in part to an assumption among the general public that individuals with disability are not sexually active and unlikely to use intravenous drugs, therefore, are at little or no risk for HIV infection. Yet recent studies note that, people with disabilities acquire HIV/AIDS up to three times greater rate of infection than do non-disabled people because of their risk for physical abuse, isolation, general poverty and lack of access to services and information. [27] To prevent transmission and to mitigate

[21] Roberts (2005).
[22] Mont (2004). In OECD, about two percentage points are attributed to disability – mainly due to higher unemployment rate of disabled people in Germany and Netherlands.
[23] Edmonds (2005).
[24] Edmonds (2005).
[25] ILO (2005).
[26] World Bank (2005d).
[27] Global survey on HIV/AIDS and disability, conducted by the World Bank and Yale University in April 2004 is one of the few studies that has attempted to estimate the prevalence of HIV/AIDS in people with disabilities in developing world. For more details, see Groce (2004).

the effects of HIV/AIDS, people with disabilities must be actively targeted, as well as included in prevention and care efforts.

People with disabilities face increased risk of infection due to sexual exploitation and misconceptions about their sexuality and rights.[28] They are more likely to be victims of violence or rape with limited power to negotiate for safer sex, but less likely to be able to obtain police intervention, legal protection or prophylactic care. Some subgroups within the disabled population-–most notably women, youth, ethnic minorities, and individuals who live in institutions–-are particularly at higher risk. For example, women with disabilities are especially vulnerable as they are (compared with both non-disabled women and disabled men) more likely to be uneducated or unmarried. In some communities, "virgin cleansing," the belief that sex with a virgin can cure AIDS has fueled some violence.

Reaching disabled individuals with targeted messages about HIV and AIDS, clinical care, and reproductive health services presents unique challenges.[29] Even when AIDS messages do reach disabled populations, low literacy rates and limited education levels complicate the comprehension of these messages.[30] Literacy is vital to understanding HIV messages and translating them into individual behavior change. However, the global literacy rate for adults with disability is as low as three percent and one percent for women with disability.[31] In addition, HIV messages and communication are often inaccessible to people who are blind or deaf, and health service facilitates are often inaccessible to people with physical disabilities.[32] Furthermore, disabled people are often denied access to reach HIV/AIDS testing centers and clinics. Frequently, disabled people report that they are ignored by clinical staff that tells them that disabled people "cannot get AIDS". Where AIDS medications are scarce and where services and support for individuals with HIV or AIDS are limited, individuals with pre-existing disabilities report being placed last on the list of those entitled to care.[33]

The disabling effects of AIDS on previously non-disabled individuals are well established, but other issues have received less attention. For example, intra-utero exposure to the HIV virus can cause significant developmental delays, while considerable attention has been given to the disabling effects of HIV/AIDS on previously healthy people.

Violence and Abuse

Men and women with disabilities are more vulnerable to physical, psychological, sexual or financial violence, and in particular, they are vulnerable to neglect, entrapment, and degradation. Disabled women, youth and children are especially at higher risk of being mentally or physically abused. They are generally more likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence. Also, disabled women are twice as likely to experience domestic violence as non-disabled women.[34] Often for disabled people, their abuser may also be their care giver, someone that the individual is reliant on for personal care or

[28] Yousafzi and Edwards (2004).
[29] Groce (2004).
[30] World Bank (2004).
[31] Helander (1998).
[32] World Bank (2004).
[33] World Bank (2004).
[34] 1995 British Crime Survey, also confirmed by data from other countries.
http://www.womensaid.org.uk/domestic-violence-survivors
handbook.asp?section=000100010008000100350003

mobility. Abuse by household members often remains unreported to avoid further stigmatization.[35] Furthermore, disabled people tend to lack access to legal protection.[36] In addition, domestic violence and abuse a significant cause of physical and mental disabilities in women.

Post-Conflict/Disaster Reconstruction

Conflicts and natural disasters can be both a direct or indirect cause of disabilities; they cause significant numbers of physical and psycho-social disability directly through injuries, sexual abuse, mental and emotional distress, or indirectly though disruption of health and education services, lack of fuel, water, energy and jobs.[37] Conflict and disasters are major causes of disability, but they also have a greater impact on those who are disabled, as such events with lack of access to information and services.[38] [39]

Disabilities place a large economic burden, not only on the individuals who are disabled, but also on the family. For example, conflicts and disasters are often associated with high prevalence of mental and psycho-social health problems, including post-traumatic stress disorder (PTSD). These "hidden disabilities" often affect a large proportion of the general population over a long period of time, and the economic and social impact can be quite devastating unless addressed at an early point. Recent research reveals that in post-conflict societies, mental health disorders represent a major obstacle to economic development through lost productivity, loss of learning capacity, and cost of treatment and care.[40] Failure to address these issues, therefore, can leave the society vulnerable to a return to violence and inhibit efforts to rebuild social capital and social and economic development.[41]

In the past, the emphasis on disability has often been concentrated on the emergency phase after the conflict or catastrophe, or with a focus limited to certain issues such as land mines.[42] While these areas remain critical, disability issues need to be examined in wider scope; functional limitations acquired during conflicts or catastrophes generate a more long-term need for continued integrated management, care, social support and reintegration into society. In the recent

[35] Elwan (1999).
[36] *Violence and Crimes against Disabled Persons Bibliography*. The University of Wyoming has published a comprehensive bibliography focused on violence and crimes against people with disabilities. The document includes full citations and abstracts for almost 300 peer-reviewed articles, formal reports, books, and editorials all published between 1990 - 2006.
http://wind.uwyo.edu/resourceguide/resources/Bibliography.pdf
[37] Murthy et al (2006).
[38] Sipos (2006).
[39] It is also critical to look into the subgroups of people with disabilities. In post-conflict situation, for example, disabled civilians, especially females, have less access to prosthetics rehabilitation and other services than do soldiers (WHO, 2005). In disaster planning, "special needs" population comprises a large number of people, with largely diversified characteristics; one possible approach is to disaggregate the large generic "special needs" group in diverse sub-groups based on functional characteristics instead of other grouping. This approach may be able to include other sub-groups not identified and re-grouping them based on transversal functional needs such as mobility, hearing, speaking, learning, remembering, etc. making relatively easier disaster management planning and interventions. (see Kailes & Enders, 2006).
[40] World Bank (2005d).
[41] Edmonds (2005).
[42] Landmines constitute on ongoing cause of disabilities. Landmines alone injure a minimum of 20,000 people annually; mostly civilians and many are under 15 years of age. Globally, there are more than 350,000 disabled landmine survivors, the majority amputees (Landmine Monitor, 2005).

years, the actors operating in this field have attempted to embrace a more holistic approach that includes: data collection, analysis, monitoring and evaluation, along with continuing medical care, physical rehabilitation, prostheses and assistive devices, psychological and social support, employment and economic integration, capacity building and sustainability, legislation and public awareness, and accessibility interventions and policies.[43]

Incorporating disability into post-conflict/disaster situation with long-term perspective is particularly important as it (ironically) opens up opportunities for reconstructing infrastructure that lends itself to a more inclusive way, including using principles of universal design (see Box 8). In post-conflict/disaster environments, where the prevalence of impairments and disability is especially high, disabled people should be included in the short- and long-term needs-assessments and management of emergency operations, reconstruction and development. Further enhanced coordination with stronger linkages between emergency and development aid, ensuring sustainable financing, utilizing this opportunity for creation of a "new" and more inclusive society is key to sustainable development.[44]

Community Driven Development

Community Driven Development (CDD), an approach to development that emphasizes community participation and agency, provides an opportunity to integrate the concerns of vulnerable groups such as the disabled into development initiatives. A range of interventions have been adopted by CDD programs to address disability issues, including community-based rehabilitation (CBR), education and vocational training, income generation activities, building social capital and advocacy and policy reform.[45]

Community-based rehabilitation (CBR) is an approach that has grown out of the need for bringing integrated health and social services closer to the people. CBR links the medical and social models of disability, as it attempts to combine physical rehabilitation and continued medical care with empowerment and social inclusion through the participation of both the individual with a disability and the community in the process of rehabilitation and management of chronic functional impairment. It is estimated that the rehabilitation needs of 80 percent of people with disabilities could be satisfied at community level.[46] The remainder is likely to require some referral to more specialized facilities.

CBR is often the best approach to inclusion and social integration, as it promotes and protects human rights while creating equal opportunities and making the best use of scarce resources. CBR empowers individuals to take action to improve their own lives. Rehabilitation takes place within the community and is fully participatory. Community members with and without disabilities are the core resources. CBR depends heavily on empowerment of the local community specialist inputs, such as medical and orthopedic care, as well as supplies (e.g., prosthetics) remain important, inputs, but within a broader more socio-cultural context. Value is placed on indigenous knowledge and practices, the key being to 'unlock' existing expertise within communities enabling them to develop their own community process that builds on and validates existing indigenous knowledge and information systems, while facilitating access to relevant information and ideas from outside the community.

The concept of CBR has won widespread support, but in some cases negative institutional practices and attitudes have simply been relocated to the community. Also, it often takes place on a small geographical scale, not providing a global solution.

[43] World Bank Disability Website.
[44] Rockhold (2006a).
[45] World Bank website: Disability and Community Driven Development.
[46] DFID (2000).

It is essential that people with disabilities exercise choice and control over CBR initiatives moving toward a more inclusive approach, placing disability into a wider community development framework.[47] Community based self determination programs are particularly favored, where people with disabilities support each other in rehabilitation, income generation and advocacy. The long-term goal of CBR should be to support people with disabilities in their efforts to take control of their own lives and to play a decisive role in any services that are created.

For CDD to be truly effective as an approach toward promoting the inclusion of disabled people, both micro and macro approaches need to be integrated. Some emerging lessons on ways to include disabled people in CDD programs are:

- A twin track approach of targeting people with disabilities, as well as integrating their voices and needs within the broader project cycle should be followed. While it is important to have specific sub-projects with an emphasis on addressing disability concerns, communities should be encouraged to identify and incorporate the voices and the needs of vulnerable groups.
- A strong enabling environment, wherein disability concerns are mainstreamed into institutional frameworks, and are supported by progressive legislation, is critical to empowering disabled people. To ensure sustainability, it is also important that multiple stakeholders such as the local government, civil society organizations, and the private sector, as well as the disabled people be involved.
- Project staff should be equipped in terms of capacities and resources to integrate disability in CDD programs. People with disabilities should be employed as facilitators and project managers to ensure self-representation and better outreach.
- Inclusion of disabled people can be accomplished only if a "vulnerability perspective" is integrated in all aspects of CDD operations. Disability, much like gender, is a cross-cutting issue and should be incorporated in all stages of the project cycle--design and appraisal, implementation, review and evaluation.

Finally, it is important to balance the participatory and demand-driven approach of CDD programs with social protection mechanisms that include the special needs of vulnerable groups as part of a rights-based paradigm. The conventional demand-driven approach often tends to exclude vulnerable groups due to it's over emphasis on active participation. Owing to historical, systemic, and physical barriers, disabled people, especially severely disabled, can only participate in the process of decision-making if they are included in the entire project phase. Therefore, it is important to complement participatory processes with the provision of safety nets to not only, ensure that the needs of people with disabilities are included in CDD programs, but also the people themselves.[48]

[47] Working Group on Disability and Development of the British Organization of NGOs for Development (BOND).
[48] World Bank (2005f).